Notice of

Rulemaking Hearing

Tennessee Department of Finance and Administration

Bureau of TennCare

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act Tennessee Code Annotated, Section 4-5-204 and will take place in the Bureau of TennCare, 1st Floor East Conference Room, 310 Great Circle Road, Nashville, Tennessee 37243 at 9:00 a.m. C.S.T. on the 18th March 2008.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Finance and Administration, Bureau of TennCare, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings) to allow time for the Bureau of TennCare to determine how it may reasonably provide such aid or service. Initial contact may be made with the Bureau of TennCare's ADA Coordinator by mail at the Bureau of - TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6474 or 1-800-342-3145.

For a copy of this notice of rulemaking hearing, contact George Woods at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or call (615) 507-6446.

Substance of Proposed Rules

Paragraph (2) Access To Health Insurance of rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with a new paragraph (2) which shall read as follows:

(2) Access To Health Insurance shall mean the opportunity an individual has to obtain group health insurance as defined elsewhere in these rules. If a person could have enrolled in work-related or other group health insurance during an employer's or group's open enrollment period and chose not to enroll (or had the choice made for him by a family member) that person shall not be considered to lack access to insurance upon closure of the open enrollment period. Neither the cost of an insurance policy or health plan nor the fact that an insurance policy is not as comprehensive as that of the TennCare Program shall be considered in determining eligibility to enroll in any TennCare category where being uninsured is an eligibility prerequisite.

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (5) and the current paragraph (5) is renumbered as paragraph (6) and subsequent paragraphs renumbered accordingly so as amended the new paragraph (5) shall read as follows:

(5) Application Period shall mean a specific period of time determined by the Bureau of TennCare during which the Bureau will accept applications for the TennCare Standard Spend Down category as described in the Bureau's rules at 1200-13-14-.02.

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (9) and the subsequent paragraphs are renumbered accordingly so as amended the new paragraph (9) shall read as follows:

(9) CALL-IN LINE shall mean the toll-free telephone line used as the single point of entry during an open application period to accept new applications for the Standard Spend Down Program.

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (12) and the subsequent paragraphs are renumbered accordingly so as amended the new paragraph (12) shall read as follows:

(12) Caretaker Relative shall mean that individual as defined at *Tennessee Code Annotated* § 71-3-153.

Paragraph (15) Community Service Area of rule 1200-13-14-.01 Definitions, renumbered as paragraph (18), is deleted in its entirety and subsequent paragraphs are renumbered accordingly.

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (22) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (22) shall read as follows:

(22) Core Medicaid Populaton shall mean individuals eligible under Title XIX of the Social Security Act, 42 U.S.C. §§1396, et seq., with the exception of the following groups: individuals receiving SSI benefits as determined by the Social Security Administration; individuals eligible under a Refugee status; individuals eligible for emergency services as an illegal or undocumented alien; individuals receiving interim Medicaid benefits with a pending Medicaid disability determination; individuals with forty-five (45) days of presumptive eligibility; and children in DCS custody.

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (30) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (30) shall read as follows:

(30) Discontinued Demonstration Group shall mean the group of non-Medicaid eligible individuals who were enrolled in TennCare Standard on April 29, 2005, when the categories in which they were enrolled were terminated, and who have not yet been enrolled in TennCare Medicaid or disenrolled from the TennCare program.

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (43) and the subsequent paragraphs are renumbered accordingly so as amended the new paragraph (43) shall read as follows:

(43) Grand Divisions shall mean the three (3) distinct geographic areas of the State of Tennessee, known as Eastern, Middle, and Western, as designated in *Tennessee Code Annotated* § 4-1-201.

Paragraph (82) Prospective Enrollment of rule 1200-13-14-.01 Definitions, renumbered as paragraph (87), is deleted in its entirety and subsequent paragraphs are renumbered accordingly.

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (101) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (101) shall read as follows:

(101) Responsible Party(Ies) shall mean the following individuals, who are representatives and/or relatives of recipients of medical assistance who are not financially eligible to receive benefits: parents, spouses, children, guardians; as defined at *Tennessee Code Annotated* § 71-5-103(10).

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (105) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (105) shall read as follows:

(105) Standard Spend Down (Ssd) shall mean the demonstration eligibility category composed of adults aged twenty-one (21) and older who have been found to meet the criteria in Rule 1200-13-14-.02.

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (106) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (106) shall read as follows:

(106) Target Population Group (TPG) shall mean a group identified by means of an assessment mechanism for children and adolescents under the age of eighteen (18) which determines a

service recipient's level of functioning and severity of impairment due to mental illness. Based on the assessment criteria, there are two (2) target population groups:

(a) TPG 2: Seriously Emotionally Disturbed (SED).

These are children and adolescents who are under eighteen (18) years of age with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children are currently severely impaired as evidenced by a Global Assessment of Functioning score of 50 or less.

(b) TPG 3: At Risk of being SED.

These are children and adolescents who are under eighteen (18) years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children may or may not be currently seriously impaired as evidenced by a Global Assessment of Functioning. These children have psychosocial issues that can potentially place them at risk of becoming SED.

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (113) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (113) shall read as follows

(113) Tenncare Medicaid Eligibility Reforms shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to close enrollment into TennCare Medicaid for non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance and to disenroll non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance after completion of their twelve (12) months of eligibility.

Paragraph (110) Tenncare Standard of rule 1200-13-14-.01 Definitions, renumbered as paragraph (118), is deleted in its entirety and replaced with a new paragraph (118) which shall read as follows:

(118) Tenncare Standard shall mean that part of the TennCare Program which provides health coverage for Tennessee residents who are not eligible for Medicaid and who meet the eligibility criteria found in rule 1200-13-14-.02.

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (123) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (123) shall read as follows:

(123) Transition Group shall mean existing Medically Needy adults age twenty-one (21) or older enrolled as of October 5, 2007, who have not yet been assessed for transition to the Standard Spend Down Demonstration population for non-pregnant adults age twenty-one (21) or older.

Paragraph (115) Transition Period of rule 1200-13-14-.01 Definitions, renumbered as paragraph (124), is deleted in its entirety and subsequent paragraphs are renumbered accordingly.

Paragraph (119) Waiver Eligible of rule 1200-13-14-.01 Definitions, renumbered as paragraph (127), is deleted in its entirety.

Rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with a new rule 1200-13-14-.02 Eligibility which shall read as follows:

1200-13-14-.02 Eligibility.

(1) Delineation of agency roles and responsibilities.

(a) The Tennessee Department of Finance and Administration (F&A) is the lead State agency for the TennCare Program.

(b) The Bureau of TennCare (Bureau) is the administrative unit within F&A with the responsibility for day-to-day operations of the TennCare Program. The Bureau is responsible for establishing policy and procedural requirements and criteria for TennCare. With respect to the eligibility of children applying for TennCare as medically eligible persons, the Bureau is responsible for determining the presence of a qualifying medical condition under TennCare Standard.

(c) The Tennessee Department of Human Services (DHS) is under contract with the Bureau to determine initial eligibility for TennCare Medicaid and TennCare Standard, as well as to redetermine, at regular intervals, whether eligibility should be continued. DHS is not responsible for making decisions about the presence of a qualifying medical condition for those applying as medically eligible persons under TennCare Standard.

(d) The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) Program. Tennessee residents determined eligible for SSI benefits are automatically eligible for and enrolled in TennCare Medicaid.

(e) The Tennessee Department of Health (DOH) determines presumptive eligibility under TennCare Medicaid for pregnant women and for women diagnosed with breast or cervical cancer through administration of the Breast and Cervical Cancer Screening Program.

(2) Delineation of TennCare enrollee's responsibilities.

(a) It is the responsibility of each TennCare enrollee to report to the DHS any material change affecting any information given by the applicant/enrollee to DHS at the time of application or redetermination of his eligibility. This information includes, but is not limited to, changes in address, income, family size, employment, or access to insurance. The applicant/enrollee shall mail, or present in person, documentation of any such change to the DHS county office where the enrollee resides. This documentation must be presented within the time frame established by *Tennessee Code Annotated* § 71-5-110 for reporting changes.

(b) It is the responsibility of each TennCare enrollee to report to his provider that he is a TennCare enrollee.

(3) Technical and financial eligibility requirements for TennCare Standard.

To be eligible for TennCare Standard, each individual must:

(a) Not be eligible for Medicaid as determined by DHS.

(b) Provide a statement from his employer, if employed, concerning the availability of group health insurance. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category.)

(c) Be a U.S. citizen, lawfully admitted alien, or an alien permanently residing in the U.S. under color of law.

(d) Be a Tennessee resident as described under federal and state law.

(e) Present a Social Security number or proof of having applied for one, or assist the DHS caseworker in applying for a Social Security number, for each person applying for TennCare Standard.

(f) Not be an inmate as defined in these rules.

(g) Not be eligible for or have purchased other health insurance as defined at rule 1200-13-14-.01, except for persons in the category of uninsured children under the age of nineteen (19) whose family income is below two hundred percent (200%) of poverty and who have been continuously enrolled in TennCare Standard since at least December 31, 2001. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category.)

(h) Not be enrolled in, or eligible for participation in, Medicare. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category.)

(4) General application requirements.

(a) By applying for TennCare, an applicant grants permission and authorizes release of information to the Bureau, or its designee, to investigate any and all information provided, or any information not provided if it could affect eligibility, to determine TennCare eligibility; and if approved, what cost sharing, if any, may be required of the applicant as found in these rules. Information may be verified through, but not limited to, the following sources:

1. The United States Internal Revenue Service (IRS);

2. State income tax records for Tennessee or any other state where income is earned;

3. The Tennessee Department of Labor and Work Force Development, and other Employment Security offices within any state where the applicant may have received wages or been employed;

4. Credit bureaus;

5. Insurance companies; or,

6. Any other governmental agency or public or private source of information where such information may impact an applicant's eligibility or cost sharing requirements for the TennCare Program.

(b) By applying for TennCare, an applicant understands it is a felony offense, pursuant to *Tennessee Code Annotated* § 71-5-2601, to obtain TennCare coverage under false means or to help anyone get on TennCare under false means.

(5) TennCare Standard: Uninsured and medically eligible children.

(a) Coverage groups:

1. Group 1: Uninsured children under age nineteen (19) who are losing eligibility for Medicaid, who have family incomes below two hundred percent (200%) of poverty, and who do not have access to insurance.

2. Group 2: Uninsured children under age nineteen (19) who are losing eligibility for Medicaid, who have family incomes that equal or exceed two hundred percent

(200%) of poverty, who do not have access to insurance, and who have been determined medically eligible in accordance with these rules.

3. Group 3: Uninsured children under age nineteen (19) who have been continuously enrolled in TennCare Standard since December 31, 2001, who have family incomes below two hundred percent (200%) of poverty, and who have not purchased insurance even if they have access to it. This is a "grandfathered" eligibility category. At such time as a person loses eligibility in this category, he will not be able to re-enroll in it.

4. TennCare Standard is closed to new enrollment for children, except those children identified in (5)(a)1 and (5)(a)2 above.

(b) Eligibility criteria:

1. The individual must be under nineteen (19) years of age.

2. The individual must lack access to insurance, except those individuals in Group 3, defined in part (a)3 above. Individuals in Group 3 must not have purchased insurance that may be available to them.

3. For persons in Groups 1 and 3 defined in parts (a)1 and 3 above, have family incomes that do not exceed two hundred percent (200%) of poverty.

4. For persons in Group 2 defined in part (a)2 above, have been determined medically eligible in accordance with these rules.

(c) Application procedures:

1. Uninsured children.

An individual who is losing eligibility for TennCare Medicaid and who is under the age of nineteen (19) may be approved for TennCare Standard as a Medicaid "Rollover" Enrollee according to the following process:

(i) A notice will be sent by the Bureau of TennCare thirty (30) days prior to the expiration of the individual's TennCare Medicaid eligibility period. This letter will tell the individual that his eligibility for Medicaid is ending and to continue in the TennCare Program, he must go to his county DHS office and reapply as indicated in the notice.

(ii) When the individual reapplies, he will first be screened for TennCare Medicaid eligibility. If the individual is no longer TennCare Medicaid eligible, he will be screened for eligibility as a Medicaid "Rollover" Enrollee. Such enrollees submitting an application to DHS will have forty-five (45) additional days to complete the process (from the date the application is received at DHS). This includes completing the application process.

2. Medically eligible children.

(i) Applicants have two (2) options for proving medical eligibility:

(I) Option 1: A completed medical eligibility application and medical records to support any medical condition listed on the

application, with a signed release for medical records in the event additional medical records are needed.

(II) Option 2: Have a current CRG 1, 2, 3/TPG 2 assessment on file with the Bureau.

(ii) If a Medicaid enrollee under age nineteen (19) whose Medicaid eligibility is ending is determined to otherwise meet technical eligibility requirements for TennCare Standard, but is not eligible as uninsured because his income is above two hundred percent (200%) of poverty, he will be sent a letter denying TennCare Standard coverage as uninsured and notifying the enrollee that he may qualify as medically eligible. The enrollee will have forty (40) days (inclusive of mail time) to appeal the denial of TennCare Standard as uninsured.

(iii) When DHS makes the determination that the enrollee does not qualify for TennCare Standard as uninsured, TennCare will be notified and will send the enrollee a medical eligibility packet with an explanation regarding how to apply for TennCare Standard as a medically eligible person. The enrollee will have sixty (60) days from the date of the letter (inclusive of mail time) to submit his medical eligibility packet. If the individual is determined to qualify as medically eligible, coverage will be provided throughout the eligibility determination period and will continue with no break.

(iv) The required medical eligibility application information must be returned to the address specified within sixty (60) days from the date of the letter included in the packet. A medical eligibility form and documentation received after that time will not be processed as it exceeds the timely filing requirement. Packets which are not completed by the sixtieth (60^{th}) day will be denied with a notice of appeal rights and the "good cause" reasons for not completing the process timely, which include:

(I) The applicant was sick.

(II) A member of the applicant's immediate family was very sick.

(III) The applicant had a family emergency or tragedy.

(IV) The applicant could not get the medical records he needed from a provider. It was not his fault.

(V) The applicant asked for help because he had a disability. Neither the Bureau nor DHS gave the help the applicant needed.

(VI) The applicant asked for help because he does not speak English. Neither the Bureau nor DHS gave the help the applicant needed.

(v) The Bureau of TennCare will review the completed medical eligibility packet. Evaluation of completed packets will be made within thirty (30) days of receipt from the applicant. Medical Reviewers will assess the records submitted against TennCare medical insurance underwriting guidelines. Applicants who are not determined to be medically eligible by the Bureau will not be eligible for TennCare Standard. They will receive a termination notice which contains appeal rights including the right to

appeal within forty (40) days from the receipt of the termination notice. Appeals received by the Bureau after forty (40) days will be considered untimely and will not be forwarded to hearing.

(vi) Applicants deemed medically eligible by the Bureau of TennCare will be approved for TennCare Standard. The Bureau will send the applicant an approval notice of coverage. The eligibility period for medically eligible individuals is twelve (12) months. At the end of twelve (12) months, the enrollee must complete the redetermination/reapplication process.

(vii) The effective date of coverage will be the date of application.

(6) TennCare Standard: Standard Spend Down (SSD) Program.

(a) Coverage group.

Non pregnant adults, age 21 and older, who have been determined to meet criteria patterned after the Medically Needy requirements, as outlined in DHS rule 1240-3-2-.03 and who are age 65 or older, blind, disabled, or caretaker relatives of Medicaid-eligible children.

(b) Eligibility criteria:

1. Must be age twenty-one (21) or older.

2. Must not be pregnant.

3. Must meet one of the following criteria:

(i) Be sixty-five (65) years of age or older; or

(ii) Be blind, as defined in DHS rule 1240-3-3-.02; or

(iii) Be disabled, as defined in DHS rule 1240-3-3-.02; or

(iv) Be a caretaker relative, as defined at *T.C.A.* § 71-3-153.

4. Must meet the financial eligibility criteria, including income and resource limitations that apply to Medically Needy pregnant women and children eligible under the State plan. These criteria are found at DHS rules 1240-3-3-.05 and 1240-3-3-.06.

5. Must be enrolled in accordance with an enrollment target of 100,000 Tennessee residents who have been determined to be eligible for the Standard Spend Down (SSD) Program; with a maximum of 105,000 persons to be enrolled at any given time.

(c) Application procedures:

1. SSD categories.

(i) Category 1. Individuals who are not eligible for Medicaid at the time the SSD program is implemented and who meet the criteria for the new SSD program.

Category 1 applicants will be processed for eligibility only through a single toll-free telephone point of entry (the Call-in Line) initiated in periods of open enrollment. In each such period, the State will determine a specified number of calls that it will accept through the Call-in Line based on the number of Category 1 applications that the State estimates it can process within Federal timeliness standards. The number of calls to be accepted in these periods will be based on the number of remaining slots available under the enrollment target of 100,000 persons. The State will not accept or track calls received outside of these periods.

(ii) Category 2. Individuals in the Transition Group who, at the time the SSD program is implemented, are eligible for Medicaid in a non-pregnant adult Medically Needy category, who have completed their twelve (12) months of Medicaid eligibility, have been found to be ineligible for any other Medicaid category, and have been determined to meet the criteria of the SSD program.

For Category 2 individuals, the State will determine their SSD eligibility on a rolling basis in conjunction with their termination from Medicaid, and shall reserve sufficient slots within the enrollment target to ensure that all such persons who are eligible may be accepted in the SSD category.

Termination procedures for Category 2 individuals who are not eligible for Medicaid or for SSD will be conducted in accordance with those outlined in Paragraph (7)(b) of this rule.

Upon implementation of the SSD program, the State will review all Category 2 individuals for either eligibility in a new Medicaid category or approval as a Standard Spend Down eligible. After the review of all Category 2 individuals is complete and it is determined how many additional enrollees can be added to the SSD program without exceeding the enrollment cap, the State will begin enrolling persons in Category 1.

2. Initial application period for Category 1.

The State will establish an initial target enrollment figure based on its determination of the minimum number of applications the State estimates it can process in a timely manner in accordance with Federal standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions. A toll-free Call-in Line to receive requests for applications will be established and requests will be processed as follows:

(i) Callers to the Call-in Line will be asked for basic demographic information and will be assigned a unique identifier.

(ii) A match will be conducted to verify that callers are not already eligible in a TennCare Medicaid category. Those callers who are already eligible in a TennCare Medicaid category will be sent letters advising them that they currently have benefits and need not apply for Standard Spend Down.

(iii) For those callers who are not Medicaid eligible, the State will send a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within thirty (30) days.

(iv) Completed, signed applications received by the State by the thirty (30)-day deadline will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the State. If the State does not receive an application by the deadline, the State will send the individual a letter advising him that since no application was received, the State will not make an eligibility determination for him, but the individual is free to apply for SSD during any subsequent open application period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he did submit a signed, written application within the deadline.

(v) Since all SSD applications received during an open application period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open application period will be carried forward to future open application periods. The State will determine SSD eligibility within the timeframes specified by Federal regulations at 42 CFR § 435.911; such time frames will begin on the date a signed written application is received by the State.

3. New application periods after the SSD enrollment target has been reached.

Once the State has reached its targeted enrollment of 100,000 persons, new application periods will be scheduled when the number of approved eligibles in the SSD program drops to ninety percent (90%) of target enrollment, or 90,000 persons. Any subsequent application periods will remain open until a pre-determined number of calls to the Call-in Line have been received. The number of calls to be received will be based on the State's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the state estimates it can process in a timely manner in accordance with Federal standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions.

4. Period of eligibility.

All enrollees in the SSD demonstration category will have an eligibility period of twelve (12) months from the effective date of eligibility. At the end of the twelve (12)-month period each enrollee must have his eligibility redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for Medically Needy pregnant women and children in TennCare Medicaid.

5. Effective date of eligibility for SSD enrollees.

The effective date of SSD eligibility for an individual whose application for SSD eligibility is initiated through the Call-in Line and who submits a timely signed application will be the later of:

(i) The date his call was received by the Call-in Line; or

(ii) The date spend-down is met (which must be no later than the end of the one (1)-month budget period – in this case, the end of the month of the original call to the Call-in Line).

(iii) The effective date of SSD eligibility for an individual whose eligibility is being redetermined is the application date.

(iv) For Category 2 individuals the effective date will be determined in accordance with DHS rule 1240-3-1-.04.

(7) TennCare Standard: Discontinued Eligibility Group.

(a) Coverage group.

Uninsured and medically eligible individuals, age nineteen (19) and older, who were enrolled in TennCare Standard when the program was closed to persons age nineteen (19) and older on April 29, 2005, and who have not been disenrolled nor enrolled in Medicaid.

(b) Termination procedures in accordance with eligibility reforms of March 24, 2005.

Prior to the termination of TennCare Standard eligibility, Medicaid eligibility shall be reviewed in accordance with the following process:

1. Ex Parte Review.

DHS will conduct an ex parte review of eligibility for open Medicaid categories for all TennCare Standard enrollees due to be terminated. Such ex parte review shall be conducted in accordance with federal requirements as set forth by CMS in the Special Terms and Conditions of the TennCare demonstration project.

2. Request for Information.

(i) At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all TennCare Standard enrollees being terminated. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories as well as a list of the types of proof needed to verify certain information.

(ii) Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to DHS and to provide DHS with the necessary verifications to determine eligibility for open Medicaid categories.

(iii) Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.

(iv) Enrollees will be given an opportunity until the date of termination to request one extension for good cause of the thirty (30) day time frame for responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or who, as a result of a

health problem, mental health problem, learning problem, disability, or limited English proficiency, are unable to respond timely. The good cause exception does not confer an entitlement upon enrollees and the application of this exception will be within the discretion of DHS. Only one (1) thirty (30) day good cause extension can be granted to each enrollee. Good cause is determined by DHS eligibility staff. Good cause is not requested nor determined by filing an appeal. Requests for an extension of the thirty (30) day time frame to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. DHS will not accept a request for extension of the thirty (30) day time frame submitted by a family member, advocate, provider or CMHC, acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his whereabouts are unknown. All requests for a good cause extension must be made prior to termination of TennCare eligibility. A good cause extension will be granted if DHS determines that a health problem, mental health problem, learning problem, disability or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to DHS prior to termination of TennCare eligibility and DHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion of DHS and if granted shall provide the enrollee with an additional thirty (30) days inclusive of mail time from the date of DHS's decision to grant the good cause extension. DHS will send the enrollee a letter granting or denying the request for good cause extension. DHS's decisions with respect to good cause extension shall not be appealable.

(v) If an enrollee provides some but not all of the necessary information to DHS to determine his eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, DHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day time frame for responding to the Verification Request.

(vi) Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by DHS shall retain their eligibility for TennCare Standard (subject to any changes in covered services generally applicable to enrollees in their TennCare Standard category) while DHS reviews their eligibility for open Medicaid categories.

(vii) DHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or the Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If DHS makes a determination that the enrollee is eligible for an open Medicaid category,

DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. When the enrollee is enrolled in TennCare Medicaid, his TennCare Standard eligibility shall be terminated without additional notice. If DHS makes a determination that the enrollee is not eligible for any open Medicaid categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period or any extension of such period granted by DHS, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

(viii) DHS shall, pursuant to the rules, policies and procedures of DHS and the Bureau of TennCare applicable to new applicants for TennCare coverage, review all information and verifications provided by an enrollee after the thirty (30) day period following the Request for Information or after any extension of such period granted by DHS, but the enrollee shall not be entitled to retain eligibility for TennCare Standard pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of his application, or (b) the date spend down eligibility is met as defined in DHS rule 1240-3-1-.04.

3. Notice of termination.

(i) The TennCare Bureau will send Termination Notices to all TennCare Standard enrollees being terminated who are not determined to be eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in this paragraph.

(ii) Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.

(iii) Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and will inform enrollees how they may request a hearing.

(iv) Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

(v) Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day time frame in which to request a hearing.

(8) Redetermination of eligibility in TennCare Standard.

(a) All enrollees must reapply and have their TennCare coverage redetermined based on the approved policies and procedures in effect at the time of their next scheduled redetermination/reapplication process. TennCare Standard enrollees shall have their eligibility redetermined in accordance with the following process:

1. Ex Parte Review.

DHS will conduct an ex parte review of eligibility for open Medicaid categories for all TennCare Standard enrollees due for redetermination. Such ex parte reviews

shall be conducted in accordance with federal requirements set forth by CMS in the Special Terms and Conditions of the TennCare demonstration project.

2. Request for Information.

(i) At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all TennCare Standard enrollees. The Request for Information will include a form to be completed with the information needed to determine eligibility for open Medicaid categories, as well as a list of the types of proof needed to verify certain information.

(ii) Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed from to DHS and provide DHS with the necessary verifications to determine eligibility for open Medicaid categories.

(iii) Enrollees with a health problem, mental health problem, learning problem, or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.

(iv) Enrollees will be given an opportunity until the date of termination to request one (1) extension for good cause of the thirty (30) day time frame for responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or who, as a result of a health problem, mental health problem, learning problem, disability, or limited English proficiency, are unable to respond timely. The good cause exception does not confer entitlement upon enrollees and the application of this exception will be within the discretion of DHS. Only one (1) thirty (30) day good cause extension can be granted to each enrollee. Good cause is determined by DHS eligibility staff. Good cause is not requested nor determined through filing an appeal. Requests for an extension of the thirty (30) day time frame to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. DHS will not accept a request for extension of the thirty (30) day time frame submitted by a family member, advocate, provider, or CMHC, acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his whereabouts are unknown. All such requests for good cause extension must be made prior to termination of TennCare eligibility. A good cause extension will be granted if DHS determines that a health problem, mental health problem, learning problem, disability, or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to DHS prior to termination of TennCare eligibility and DHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion

of DHS and if granted shall provide the enrollee with an additional thirty (30) days inclusive of mail time from the date of DHS's decision to grant the good cause extension. DHS will send the enrollee a letter granting or denying the request for good cause extension. DHS's decisions with respect to good cause extensions shall not be appealable.

(v) If an enrollee provides some but not all of the necessary information to DHS to determine his eligibility for open Medicaid categories or continuation in TennCare Standard during the thirty (30) day period following the Request for Information, DHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day time frame for responding to the Verification Request.

(vi) Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by DHS shall retain their eligibility for TennCare Standard (subject to any changes in covered services generally applicable to enrollees in their TennCare Standard category) while DHS reviews their eligibility.

(vii) DHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or Verification Request to determine whether the enrollee is eligible for any open Medicaid categories or whether the enrollee is eligible to remain in TennCare. If DHS makes a determination that the enrollee is eligible for an open Medicaid category or to remain in TennCare Standard, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare category. When the enrollee is enrolled in TennCare Medicaid, his TennCare Standard eligibility shall be terminated without additional notice. If DHS makes a determination that the enrollee is not eligible for any TennCare category or if the enrollee does not respond to the Request for Information within the requisite thirty (30) day time frame or any extension of such period granted by DHS, the TennCare Bureau will send the enrollee a twenty- (20) day advance Termination Notice.

(viii) DHS shall, pursuant to the rules, policies, and procedures of DHS and the Bureau of TennCare applicable to new applicants for TennCare coverage, review all information and verifications provided by an enrollee after the thirty (30) day period following the Request for Information or after any extension of such period granted by DHS, but the enrollee shall not be entitled to retain eligibility for TennCare Standard pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of his application, or (b) the date spend down eligibility is met as defined in Department of Human Services rule 1240-3-1-.04.

3. Notice of Termination.

(i) The TennCare Bureau will send Termination Notices to all TennCare Standard enrollees being terminated who are not determined to be

eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in this subparagraph.

(ii) Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.

(iii) Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and will inform enrollees how they may request a hearing.

(iv) Enrollees with a health problem, mental health problem, learning problem, or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

(v) Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day time frame in which to request a hearing.

(b) A TennCare Standard enrollee shall be required to have his eligibility redetermined for TennCare Standard prior to the expiration date of the current period of coverage as instructed by the DHS. The enrollee's continued eligibility for TennCare Standard is determined as of the date of the redetermination appointment or a later date if the enrollee does not submit all required documentation at the initial appointment. (The later date must be before the date of expiration of coverage.)

(c) Information to be recertified includes changes in address, income, employment, family size, and access to health insurance. Redetermination appointments must be scheduled and kept regardless of whether any changes have occurred. It is the responsibility of the enrollee to furnish all information requested. The notice reminding the enrollee that he must have his eligibility redetermined will inform the enrollee of the documentation to be brought to the appointment.

(d) The enrollee must complete the entire redetermination process prior to the expiration date of his coverage. Failure to do so will result in coverage lapsing as of the expiration date. The enrollee will not be permitted to appeal the expiration of his coverage in this situation. However, he may appeal on the grounds that:

1. He did, in fact, complete the redetermination process but an administrative error on the part of the State resulted in his coverage expiring; or

2. He was prevented from completing the redetermination process by specific acts or omissions of state employees. However, this ground for appeal does not include challenges to relevant TennCare rules, policies or timeframes.

The individual will receive a notice of the expiration of his coverage and his right to appeal, as set out above, within ten (10) days. There will be no continuation or reinstatement of coverage pending appeal.

(e) Enrollees approved for TennCare Standard as medically eligible persons may also be required to submit proof of continued medical eligibility. Documentation shall be that as required elsewhere in these rules. If as a result of the redetermination appointment it is determined that any enrollee no longer meets the technical eligibility requirements set out at rule 1200-13-14-.02, the enrollee will be disenrolled from TennCare Standard. The enrollee will be sent a notice of termination, and the enrollee has the right to appeal the decision within forty (40) calendar days of the receipt of the letter informing the enrollee of the loss of eligibility. The enrollee's right to appeal is set out at rule 1200-13-14-.12.

(9) Losing eligibility for TennCare Standard.

Eligibility for TennCare Standard shall cease when it has been determined that the enrollee, as the result of one of the following events, no longer meets the criteria for the program. Eligibility for TennCare Standard shall end if:

(a) The enrollee becomes eligible for participation in a group health insurance plan, as defined in these rules, either directly or indirectly through a family member. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category);

(b) The enrollee becomes eligible for Medicare. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category);

(c) The enrollee is determined eligible for Medicaid;

(d) The enrollee purchases an individual health insurance plan as defined by these rules. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category);

(e) The enrollee fails to comply with TennCare Program requirements, subject to federal and state laws and regulations;

(f) The enrollee dies;

(g) It is determined that any of the technical eligibility requirements found in these rules are no longer met;

(h) The enrollee has failed to respond to a redetermination process requirement, as described in these rules, to assure that the enrollee and other family members, as appropriate, remain eligible for TennCare Standard;

(i) The enrollee sends a voluntary written request for termination of eligibility for TennCare Standard to the DHS county office in the county in which he resides;

(j) The enrollee no longer qualifies as a resident of Tennessee under federal and state law;

(k) The enrollee fails to complete the reverification process within the timeframes specified within these rules;

(l) The enrollee becomes incarcerated as an inmate;

(m) The Bureau determines that the enrollee does not actually have the medical condition(s) which rendered him “medically eligible” for TennCare Standard; or

(n) The enrollee attains the age of nineteen (19) and has not been determined eligible in an open Medicaid category.

TennCare Standard enrollees who are disenrolled from TennCare pursuant to these rules shall be allowed to re-enroll in the TennCare program at any time if they become TennCare Medicaid-eligible and shall not be required to pay arrearages as a condition of re-enrollment. However, nothing in this provision shall eliminate the enrollee’s responsibility for unpaid premiums or copayments incurred under any previous period of eligibility.

Rule 1200-13-14-.03 Enrollment, Disenrollment, Re-Enrollment, And Reassignment is deleted in its entirety and replaced with a new rule 1200-13-14-.03 which shall read as follows:

1200-13-14-.03 Enrollment, Reassignment, And Disenrollment With Managed Care Contractors (Mccs)

(1) Enrollment.

There are four different types of managed care entities that provide services to TennCare enrollees. Enrollment procedures differ according to the type of managed care entity, the geographic area, and the number of managed care entities operating in each geographic area.

(a) TennCare Managed Care Organizations (MCOs) other than TennCare Select.

1. Individuals or families determined eligible for TennCare shall select a health plan (Managed Care Organization/MCO) at the time of application. The health plan must be available in the Grand Division of the state in which the enrollee lives. Every attempt will be made to enroll eligible family members in the same MCO with the exception of a family member assigned by the Bureau to TennCare Select. An enrollee is given his choice of MCOs when possible. If the requested MCO cannot accept new enrollees, the Bureau will assign each enrollee to an MCO that is accepting new enrollees. If no MCO is available to enroll new members in the enrollee's Grand Division, the enrollee will be assigned to TennCare Select until such time as another MCO becomes available. The Bureau may also assign TennCare children with special health care needs to TennCare Select.

2. A TennCare enrollee may change MCOs one (1) time within the initial forty-five (45) calendar days (inclusive of mail time) from the date of the letter informing him of his MCO assignment, if there is another MCO in the enrollee's Grand Division that is currently permitted by the Bureau to accept new enrollees. No additional changes will be allowed except as otherwise specified in these rules. An enrollee shall remain a member of the designated plan until he is given an opportunity to change during an annual redetermination of eligibility. Thereafter, only one (1) MCO change is permitted every twelve (12) months, unless the Bureau authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment as specified in subparagraph (2)(b) below. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until he is enrolled in the requested MCO.

3. Each MCO shall offer enrollees, to the extent possible, freedom of choice among participating providers. If after notification of enrollment the enrollee has not chosen a primary care provider, one will be selected for him by the MCO. The period during which an enrollee may choose his primary care provider shall not be less than fifteen (15) calendar days.

4. In the event a pregnant woman entering an MCO's plan is receiving medically necessary prenatal care the day before enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the MCO's provider network until such time as the MCO can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health.

In the event a pregnant woman entering the MCO's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the MCO shall be responsible for providing

continued access to the provider (regardless of network affiliation) through the postpartum period. Reimbursement to an out-of-network provider shall be as set out in rule 1200-13-14-.08.

(b) TennCare Select.

TennCare Select is a prepaid inpatient health plan (PIHP), as defined in 42 CFR 438.2, which operates in all areas of the State and covers the same services as the MCOs. The State's TennCare Select contractor is reimbursed on a non-risk, non-capitated basis for services rendered to covered populations, and in addition receives fees from the State to offset administrative costs.

1. The TennCare populations included in the TennCare Select delivery system are as follows:

   (i) Children under the age of nineteen (19) years who are eligible for Supplemental Security Income.

   (ii) Children in state custody and children leaving state custody for six (6) months post-custody as long as the child remains eligible.

   (iii) Children under the age of nineteen (19) years in an institutional eligibility category who are receiving care in a Nursing Facility, an Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services 1915(c) waiver.

   (iv) Enrollees living in areas where there is insufficient MCO capacity to service them.

   After being assigned to TennCare Select, persons in categories (i) and (iii) above may choose to disenroll from TennCare Select and enroll in another MCO if one is available. Persons in categories (ii) and (iv) must remain in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

2. TennCare Select also provides the following functions:

   (i) It is the back-up plan should one of the MCOs leave the TennCare program unexpectedly. For TennCare enrollees previously enrolled with the MCO, TennCare Select provides medical case management and all MCO covered services.

   (ii) It is the only entity responsible for payment of the services described in 42 CFR 431.52, services provided to residents temporarily absent from the State, and provides all MCO covered services (primarily emergency services).

   (iii) It is also the only entity responsible for payment of the services described in 42 CFR 440.255, emergency services for certain aliens.

(c) TennCare Behavioral Health Organization (BHO).

In any Grand Division of Tennessee where behavioral health services are not offered by MCOs, enrollees shall be assigned to the Behavioral Health Organization (BHO) that corresponds with the MCOs they have chosen.

(d) TennCare Dental Benefits Manager (DBM).

TennCare children shall be assigned to the Dental Benefits Manager (DBM) under contract with the Bureau to provide dental benefits through the TennCare Program.

(e) TennCare Pharmacy Benefits Manager (PBM).

TennCare enrollees who are eligible to receive pharmacy services shall be assigned to the Pharmacy Benefits Manager (PBM) under contract with the Bureau to provide pharmacy benefits for both medical and behavioral health services through the TennCare Program.

(2) Reassignment.

(a) Reassignment to an MCO other than the current MCO in which the TennCare enrollee is enrolled is subject to another MCO's capacity to accept new enrollees and must be approved by the Bureau of TennCare in accordance with one of the following:

1. During the initial forty-five (45) day period following notification of MCO assignment as described at rule 1200-13-14-.03, a TennCare Standard enrollee may request a change of MCOs.

2. A TennCare enrollee must change MCOs if he moves outside the MCO's Grand Division, and that MCO is not authorized to operate in the enrollee's new place of residence. Until the TennCare enrollee selects or is assigned to a new MCO and his enrollment is deemed complete, his medical care will remain the responsibility of the original MCO.

3. If an enrollee's MCO withdraws from participation in the TennCare Program, TennCare will assign him to a MCO operating in his Grand Division, if one is available. The enrollee will be provided notice of the change and will have forty-five (45) days to select another MCO is his Grand Division. If no MCO is available to accept enrollees from an exiting plan, the enrollees will be assigned to TennCare Select until such time as another MCO becomes available.

4. A TennCare enrollee will be given an opportunity to change MCOs during the annual redetermination of eligibility. Only one (1) MCO change is permitted every twelve (12) months, unless the Bureau authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until enrolled in the requested MCO.

(b) A TennCare enrollee may change MCOs if the TennCare Bureau has granted a request for a change in MCOs or an appeal of a denial of a request for a change in MCOs has been resolved in his favor based on hardship criteria.

1. The following situations will not be determined to be "hardships":

(i) The enrollee is unhappy with the current MCO or primary care provider (PCP), but there is no hardship medical situation (as stated in Part 2 below);

(ii) The enrollee claims lack of access to services but the plan meets the state's access standard;

(iii) The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;

(iv) The enrollee is concerned that a current provider might drop out of the plan in the future; or

(v) The enrollee is a Medicare beneficiary who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation.

2. Requests for hardship MCO reassignments must meet all of the following six (6) hardship criteria for reassignment. Determinations will be made on an individual basis.

(i) A member has a medical condition that requires complex, extensive, and ongoing care; and

(ii) The member's PCP and/or specialist has stopped participating in the member's current MCO network and has refused continuation of care to the member in his current MCO assignment; and

(iii) The ongoing medical condition of the member is such that another physician or provider with appropriate expertise would be unable to take over his care without significant and negative impact on his care; and

(iv) The current MCO has been unable to negotiate continued care for this member with the current PCP or specialist; and

(v) The current provider of services is in the network of one or more alternative MCOs; and

(vi) An alternative MCO is available to enrolled members (i.e., has not given notice of withdrawal from the TennCare Program, is not in receivership, and is not at member capacity for the member's region).

Requests to change MCOs submitted by TennCare enrollees shall be evaluated in accordance with the hardship criteria referenced above. Upon denial of a request to change MCOs, enrollees shall be provided notice and appeal rights as described in applicable provisions of rule 1200-13-14-.11.

(c) Enrollees who are out-of-state on a temporary basis, but maintain their status as a Tennessee resident under federal and state laws, shall be reassigned to TennCare Select for the period they are out-of-state.

(3) Disenrollment.

(a) When it has been determined that an individual no longer meets the criteria for TennCare eligibility, that individual shall be disenrolled from the TennCare Program. Services provided by the TennCare MCO in which the individual has been placed, as well as the BHO, PBM, and DBM, if applicable, shall be terminated upon disenrollment. Such disenrollment action will be accompanied by appropriate due process procedures as described elsewhere in these rules.

(b) Coverage shall cease at 12:00 midnight, local time, on the date that an individual is disenrolled from TennCare.

(c) TennCare may reassign individuals from a designated MCO and place them in another MCO as described elsewhere in these rules. A TennCare MCO may not reassign an

enrollee without the permission of TennCare. A TennCare MCO shall not request the reassignment of a TennCare enrollee for any of the following reasons:

1. Adverse changes in the enrollee's health;

2. Pre-existing medical conditions; or

3. High cost medical bills.

Coverage by a particular MCO shall cease at 12:00 midnight local time on the date that an individual has been reassigned by TennCare from one MCO and placed in another plan. Coverage by the new MCO will begin when coverage by the old MCO ends.

Part 26. of subparagraph (b) of paragraph (1) of rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with a new Part 26. which shall read as follows:

SERVICE	**BENEFIT FOR PERSONS UNDER AGE 21**	**BENEFIT FOR PERSONS AGED 21 AND OLDER**
26. Pharmacy Services [defined at 42 CFR §440.120(a) and obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy, or those administered to a long term care facility (nursing facility) resident].	Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office, which are the responsibility of the MCO. For TennCare Standard children under age 21 who are Medicare beneficiaries, TennCare pays for medically necessary outpatient prescription drugs when they are covered by TennCare but not by Medicare Part D. Pharmaceuticals supplied and administered in a doctor's office to persons under age 21 are the responsibility of the MCO if not covered by Medicare.	Not covered; except that adults enrolled in the Standard Spend Down (SSD) category have the same pharmacy benefits as adults in TennCare Medicaid, i.e., pharmacy services are limited to five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. Additional drugs for these enrollees shall not be covered. Prescriptions shall be counted beginning on the first day of each calendar month. Each prescription and/or refill counts as one (1). A prescription or refill can be for no more than a thirty-one (31) day supply. The Bureau of TennCare shall maintain an Automatic Exception List of medications which shall not count against such limit. The Bureau of TennCare may modify the Automatic Exception List at its discretion. The most current version of the Automatic Exception List will be made available to enrollees via the internet from the TennCare website and upon request by mail through the DHS Family

		Service Assistance Centers. Only medications that are specified on the current version of the Automatic Exception List that is available on the TennCare website located on the World Wide Web at www.state.tn.us/tenncare on the date of service shall be considered exempt from applicable prescription limits. The Bureau of TennCare shall also maintain a Prescriber Attestation List of medications available when the prescriber attests to an urgent need. The State may include certain drugs or categories of drugs on the list, and may maintain and make available to physicians, providers, pharmacists and the public, a list that shall indicate the drugs or types of drugs the State has determined to include. Drugs on the Prescriber Attestation List may be approved for enrollees who have already met an applicable benefit limit only if the prescribing professional seeks and obtains a special exemption. In order to obtain a special exemption, the prescribing provider must submit an attestation as directed by TennCare regarding the urgent need for the drug. TennCare will approve the prescribing provider's determination that the criteria for the special exemption are met, without further review, within 24 hours of receipt. Enrollees will not be entitled to a hearing regarding their eligibility for a special exemption if (i) the prescribing provider has not submitted the required attestation, or (ii) the requested drug is not on the Prescriber Attestation List. Pharmacy services in excess

		of five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) are brand name drugs, are non-covered services, unless: (a) each excess drug is specified on the current version of the Prescriber Attestation List and a completed Prescriber Attestation is on file for each listed drug as of the date of the pharmacy service; or (b) the excess drug is specified on the Automatic Exception List of medications which shall not count against such limit. Over-the-counter drugs for Medicaid adults are not covered even if the enrollee has a prescription for such service, except for prenatal vitamins for pregnant women. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in the doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are not covered by TennCare. Certain drugs known as DESI, LTE or IRS drugs are excluded from coverage.

Statutory Authority: T.C.A. 4-5-202, 4-5-203, 71-5-105, 71-5-109, Executive Order No. 23.

The notice of rulemaking set out herein was properly filed in the Department of State on the 31st day of January, 2008. (FS 01-16-08; DBID 811)